RESIDENT INTAKE Form

Date: _____ Interviewer: _____

Demographic Information

Last Name:	First Name:	Middle Initial:
Maiden/Alias:	Date of Birth:	
❒ Male ❒ Female ❒ Transgender	Sexual Orientation _____	
Race/Ethnicity:	Veteran ❒ Yes ❒ No	
Massachusetts Resident? ❒ Yes ❒ No	❒ Homeless	
Last Known Residence:	Criteria met? ❒ Yes ❒ No	

Status:
❒ Single
❒ Married/Partnered
❒ Divorce/Separated
❒ Widow(ed)
❒ Other_____
_____

Family:
Children: ❒ Yes ❒ No How many? _____ Ages:_____
Do you have legal custody? ❒ Yes ❒ No
If no, who has legal custody? _____
Do you have physical custody? ❒ Yes ❒ No
If no, who has physical custody? _____
Do you have visitation rights? ❒ Yes ❒ No

Family Information: Please give information for members of your immediate family including name, relationship, social security number, custody status, birthdate, and sex.

Name	Relationship	SSN	Custody	DOB	Sex

Note:

Are you pregnant? ❒ Yes ❒ No ❒ Not sure Due date: _____

In Case of Emergency Notify

Name:		Phone:	
Address:		Relationship:	

❒ Release obtained ❒ Contact confirmed

Developed By: FAMILY SHELTER MODEL RECORD TEAM

Sponsored by the Department of Public Health, Bureau of Substance Abuse Services
Facilitated by The Quality Improvement Collaborative

Education - Last grade completed:	Are you able to read with comfort? ❒ Yes ❒ No
Primary Language: _____ In what language do you feel comfortable reading? _____	
Do you have a learning disability? ❒ Yes ❒ No If yes, what is it? _____	Are you hearing/visually impaired? ❒ Yes ❒ No Do you need adaptive equipment? ❒ Yes ❒ No
Do you require special accomodations due to a physical disability? ❒ Yes ❒ No If yes, what accomodations? _____	
What is your occupation?	Date last worked:
Source of income: ❒ TAFDC ❒ SSI ❒ SSDI ❒ Child Support ❒ Employment ❒ Other income (legal or illegal) If illegal income, what and how?_____ _____	
How did you support your addiction? _____	
Forms of Identification (Picture ID):	
Social Security Number:	Mass Health Number:
DSS Worker: _____ Phone Number: _____ Office: _____	DTA Worker: _____ Phone Number: _____ Office: _____

Medical Information
Physician Name:
Physician Phone Number:
Physician Office:
When was your last physical? _____
What are your immediate medical problems? _____ _____ _____
Are you receiving prenatal care? ❒ Yes ❒ No When was your first visit? _____ / Would you like information about breastfeeding? ❒ Yes ❒ No
(Optional) Do you use birth control? ❒ Yes ❒ No If yes, what? _____ Would you like more information? ❒ Yes ❒ No
Do you have any allergies (food, environment, and medication)? ❒ Yes ❒ No If yes, what? _____

Do you have Hepatitis A? ❒ Yes ❒ No If yes, have you been treated? ❒ Yes ❒ No If no, have you been vaccinated? ❒ Yes ❒ No Dates: _____	Hepatitis B? ❒ Yes ❒ No If yes, have you been treated? ❒ Yes ❒ No If no, have you been vaccinated? ❒ Yes ❒ No Dates: _____	Hepatitis C? ❒ Yes ❒ No If yes, have you been treated or are you currently in treatment? ❒ Yes ❒ No

Have you had chicken pox? ❒ Yes ❒ No If no, vaccinated? ❒ Yes ❒ No ❒ Not sure	Measles? ❒ Yes ❒ No If no, vaccinated? ❒ Yes ❒ No ❒ Not sure
When was your last TB test? _____	What was the result? ❒ Positive ❒ Negative ❒ Not sure

If you tested positive, did you receive treatment? ❒ Yes ❒ No
If no, why not? _____

What prescribed medications are you taking now? (*note to interviewer: explain your medication policy)

Type:

Dose:

Why?

Who ordered it/them?

Do you take any over-the-counter medications? ❒ Yes ❒ No
If yes, what? _____

Do you have seizures? ❒ Yes ❒ No

Eating habits: ❒ laxatives/diet pills/diarectics ❒ usually eat three meals a day ❒ eat in spurts
❒ diet often ❒ eat when you are nervous
❒ force yourself to vomit -- how often? _____
❒ eat frequently – what? _____

Do you think you may have an eating disorder (i.e., anorexia, bulimia)? ❒ Yes ❒ No ❒ Not sure

Do you have any dietary restrictions? ❒ Yes ❒ No
If yes, describe _____

How many hours do you sleep at night? _____	Do you sleepwalk? ❒ Yes ❒ No

Do you sleep during the day? ❒ Yes ❒ No If yes, how many hours? _____

What do you do or take if you can't fall asleep? _____

Substance Abuse/Treatment History

Do you think you have an alcohol problem? ❒ Yes ❒ No	Do you think you have a drug problem? ❒ Yes ❒ No
Drug(s) of choice:	

Date(s) of Treatments:	Where:	Outcome(s):

Are you currently on methadone? ❒ Yes ❒ No For how long? _____

Which program? _____

Name of counselor/clinician _____ Phone # _____

	Age of First Use	Last Use	Frequency	Usual Route
Alcohol				
Cocaine				
Crack				
Marijuana/Hashish				
Heroin				
Non Rx Methadone				
Other Opiates				
PCP				
Other Hallucinogens				
Methamphetamine				
Other Amphetamines				
Other Stimulants				
Benzodiazapines				
Other Tranquilizers				
Barbituates				
Other sedatives/Hypnotics				
Inhalants				
Cigarettes				

Laxatives				
Over the Counter (please specify):				
Other				

Have you ever had a blackout? ❒ Yes ❒ No	Any memory loss? ❒ Yes ❒ No
Have you ever attended ❒ AA ❒ NA ❒ CA ❒ OA?	Do they help? ❒ Yes ❒ No Are you still involved? ❒ Yes ❒ No

What is the longest time of sobriety you have had? _____

When was it? _____

How did you maintain sobriety? _____

What supports did you have? _____

Do you have a sponsor? ❒ Yes ❒ No

What do you think led to relapse? _____

What triggers your use? _____

How do you feel that others have been affected by your use? _____
_____

What is happening now, in your life, that causes you to want to enter this program at this time?

Please identify what you believe are personal strengths that will help you in recovery: _____
_____

Do you use tobacco? ❒ Yes ❒ No	If yes, what do you use? _____ How much per day? _____
For how long have you been using tobacco? _____	Have you ever thought of quitting? ❒ Yes ❒ No

Would you be interested in a smoking cessation program? ❒ Yes ❒ No

Are you part of a support group? ❒ Yes ❒ No	Referral _____

Do you have any other addictions? ❒ gambling ❒ scratch tickets ❒ sugar ❒ spending/shopping ❒ sex ❒ men ❒ women

Intravenous Drug User ❒ Yes ❒ No When:

Family History of Substance Abuse	
Do you have family/friends/significant other who are not clean and sober? ❒ Yes ❒ No	
Does anyone in your family have a history of substance abuse? ❒ Yes ❒ No	If yes, who? _____
Does your significant other have a history of substance abuse? ❒ Yes ❒ No	
Who of your family/friends/significant other support you in coming into the program?_____ _____	

Mental Heath History	
Have you ever been psychiatrically diagnosed? ❒ Yes ❒ No	Psychiatric Diagnosis(es):
Psychiatric Hospitalizations: ❒ Yes ❒ No	When:
Where:	How many:
Prescribed Medication: ❒ Yes ❒ No	Prescriber name: Phone:
Medication (s):	Date Last taken:
Have you stopped taking any medication in last 6 months for any reason? ❒ Yes ❒ No	Which? _____ Why? _____
Do you feel suicidal? ❒ Yes ❒ No	How often? _____
When most recently? _____	Are you willing/able to come to staff if you feel suicidal? ❒ Yes ❒ No
History of Suicide Attempts ❒ Yes ❒ No	
When:	Outcome:
Were you intoxicated when you attempted suicide? ❒ Yes ❒ No	
Do you self-mutilate? ❒ Yes ❒ No Why?_____	
Are you willing/able to come to staff if you feel you are going to cut yourself? ❒ Yes ❒ No	
History of Self Mutilation When:	Outcome:
Do you have flashbacks? ❒ Yes ❒ No	Have you felt depressed (sad, overwhelmed, tired, unmotivated)? ❒ Yes ❒ No
If you have felt depressed, why? _____	
Have you experienced deaths/losses? ❒ Yes ❒ No	
Who? _____	When? _____
Cause of death? _____	Has it been addressed (i.e., therapy)? ❒ Yes ❒ No
How has this affected you? _____ _____	

Abuse History	
Are you abusive towards yourself? ❒ Yes ❒ No	Have you ever been abusive towards yourself? ❒ Yes ❒ No
Are you physically abusive towards others? ❒ Yes ❒ No	Have you ever been physically abusive towards others? ❒ Yes ❒ No
Are you emotionally abusive towards others? ❒ Yes ❒ No	Have you ever been emotionally abusive towards others? ❒ Yes ❒ No
Are you sexually abusive towards others? ❒ Yes ❒ No	Have you ever been sexually abusive towards others? ❒ Yes ❒ No
Are you a victim of violence? ❒ Yes ❒ No	Have you ever been a victim of violence? ❒ Yes ❒ No
Please elaborate:	
Have you ever been battered? ❒ Yes ❒ No	
Have you ever been **verbally abused** (intimidated/had your pet, child, or possessions threatened)? ❒ Yes ❒ No	
If yes, what were the circumstances? _____ _____	
Do you still have a relationship with this person? ❒ Yes ❒ No	Has it been addressed (i.e., therapy)? ❒ Yes ❒ No
Have you ever been **verbally abusive towards others** (intimidated someone or threatened someone's pet, child, or possessions)? ❒ Yes ❒ No	
If yes, what were the circumstances? _____ _____	
Do you still have a relationship with this person? ❒ Yes ❒ No	Has it been addressed (i.e., therapy)? ❒ Yes ❒ No
Have you ever been **physically abused** (kicked, punched, pushed, confined, locked up)? ❒ Yes ❒ No	
If yes, what were the circumstances? _____ _____	
Did your caretaker believe you? ❒ Yes ❒ No	Do you still have a relationship with this person? ❒ Yes ❒ No
Has it been addressed (i.e., therapy)? ❒ Yes ❒ No	
Have you ever been **physically abusive towards others** (kicked, punched, pushed, confined, or locked someone up)? ❒ Yes ❒ No	
If yes, what were the circumstances? _____ _____	
Do you still have a relationship with this person? ❒ Yes ❒ No	Has it been addressed (i.e., therapy)? ❒ Yes ❒ No

Do you have an active restraining order? ❒ Yes ❒ No	Does anyone have an active one on you? ❒ Yes ❒ No Who is it on? _____
Have you ever been **sexually abused**? ❒ Yes ❒ No	
If yes, what were the circumstances? _____ _____	
Did your caretaker believe you? ❒ Yes ❒ No	Do you still have a relationship with this person? ❒ Yes ❒ No
Has it been addressed (i.e., therapy)? ❒ Yes ❒ No	
Have you ever been **sexually abusive towards others**? ❒ Yes ❒ No	
If yes, what were the circumstances? _____ _____	
Do you still have a relationship with this person? ❒ Yes ❒ No	Has it been addressed (i.e., therapy)? ❒ Yes ❒ No
Do you ever have an overwhelming urge to sexually act out with other women, men, and children? ❒ Yes ❒ No	

Legal/Court History

Have you ever been arrested? ❒ Yes ❒ No	If yes, what name(s) did you use? _____ _____
Why were you arrested?_____ _____	
What was the outcome? _____	
Have you ever been in jail/prison? ❒ Yes ❒ No	If yes, what name(s) did you use? _____ _____
Why were you in jail/prison?_____ _____	

Are you on probation/parole? ❒ Yes ❒ No	
If yes, probation/parole officer's name _____ Phone Number _____	
Who is your attorney? _____	
Do you have any open court cases? ❒ Yes ❒ No	Where? _____
When is your next court date? _____	What is/are the charge(s)?_____ _____
Do you have any outstanding warrants? ❒ Yes ❒ No	Where? _____
Will you be willing to find out if you have any outstanding warrants? ❒ Yes ❒ No	
Have you ever committed arson? ❒ Yes ❒ No	
Do you drive under the influence? ❒ Yes ❒ No	Have you ever driven under the influence? ❒ Yes ❒ No

Parenting Style	
What is your relationship with your children? _____	
Do you discipline your children? ❒ Yes ❒ No	If yes, how? _____
What do you and your children do together to have fun? _____ _____	
What do you consider to be your strengths as a parent? _____	

Community Information
How do you feel about community living? _____
How do you feel about living with other women and/or with men? _____
How do you feel about living with someone from the gay or lesbian, transgender, or bisexual population? _____ _____
Have you ever lived in a structured program? ❒ Yes ❒ No
If yes, what did you like? _____
What did you dislike? _____
How do you feel about being in this program for 9 to 12 months? _____
Please identify what you believe are personal strengths that will help you in recovery. _____ _____
What do you do for social/recreational activities? _____ _____

Statement of Applicant
I hereby certify that all questions above have been answered truthfully.
Name:_____ Date:_____

Case assigned to:	**Date:**

Notes

Medical History - self report (OPTIONAL)			
Allergies:			
Neurological: Seizures: ❒ Yes ❒ No	Age began_____		Hallucinations: ❒ Yes ❒ No
Head injury: ❒ Yes ❒ No	D.T.'s: ❒ Yes ❒ No		Blackouts: ❒ Yes ❒ No
Loss of Consciousness: ❒ Yes ❒ No	Headaches: ❒ Yes ❒ No		Peripheral Neuropathy: ❒ Yes ❒ No
Comments:			
Cardiovascular: High Blood Pressure: ❒ Yes ❒ No	Heart Attack: ❒ Yes ❒ No		When: _____
Chest pain: ❒ Yes ❒ No	Dyspnea: ❒ Yes ❒ No		PPD: ❒ Yes ❒ No Date: _____
Chest X-Ray: ❒ Yes ❒ No	Date of x-ray: _____		
Comments:			
Pulmonary: Hx of TB: ❒ Yes ❒ No	Asthma: ❒ Yes ❒ No	Emphysema: ❒ Yes ❒ No	Chronic Bronchitis: ❒ Yes ❒ No
Comments:			
Genitourinary: Hx Stones: ❒ Yes ❒ No	Hx UTI: ❒ Yes ❒ No	Hx P.I.D.: ❒ Yes ❒ No	Hx V.D.: ❒ Yes ❒ No
Comments:			
Gastrointestinal: Ulcers: ❒ Yes ❒ No	Pancreatitis: ❒ Yes ❒ No		Hepatitis: ❒ Yes ❒ No Type:_____
Cirrhosis: ❒ Yes ❒ No	Abd. Pain: ❒ Yes ❒ No		Vomiting: ❒ Yes ❒ No
Blood in Stool: ❒ Yes ❒ No	Diarrhea: ❒ Yes ❒ No		
Comments:			
Gynecological: Pregnant: ❒ Yes ❒ No	Which Trimester: _____	Abortions: ❒ Yes ❒ No	Gravida:_____ Para: _____
AB: ❒ Yes ❒ No	Last Menstrual Period:		Any Complications:
Comments:			
Musculoskeletal: Pain: ❒ Yes ❒ No	Injury: ❒ Yes ❒ No		Weakness: ❒ Yes ❒ No
Numbness: ❒ Yes ❒ No	Tingling: ❒ Yes ❒ No		

Comments:		
Diabetes: ❒ Yes ❒ No	Insulin Dependent: ❒ Yes ❒ No	Cancer: ❒ Yes ❒ No
Additional Info:		
Current Medications: Type:		
Dose:		
Hospitalizations/Operations:		
Primary Care Physician: : ❒ Yes ❒ No Name:		
Telephone:		
Mental Status at Admission (OPTIONAL)		
Oriented to person: ❒ Yes ❒ No	Place: ❒ Yes ❒ No	Time: ❒ Yes ❒ No
Depressed: ❒ Yes ❒ No	Anxiety or Tension: ❒ Yes ❒ No	Hallucinations: ❒ Yes ❒ No
Thoughts of Suicide: ❒ Yes ❒ No	Trouble Understanding: ❒ Yes ❒ No	Trouble Remembering: ❒ Yes ❒ No
Trouble concentrating: ❒ Yes ❒ No	Impaired Judgement: ❒ Yes ❒ No	
Trouble controlling violent behavior: ❒ Yes ❒ No		
Comments:		